A MENTAL HEALTH MODEL FOR COMBAT CASUALTY CARE

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The Persian Gulf War has yielded a population of battle-injured veterans who will be cared for in VA hospitals. A mental health consultant on the medical and surgical units can help patients and staff members work together to overcome the shared trauma of the war experience.

When war broke out in the Persian Gulf, we were reminded of the destructive capability of the weaponry available in military arsenals throughout the world. As health care professionals and second-line caregivers to military personnel, VA health care professionals must not forget that those weapons are aimed at vehicles, machines, and other logistical targets that are operated by men and women. These men and women will absorb the impact of the bullets, bombs, missiles, and other military hardware utilized during wartime. Obviously, many will suffer traumatic injuries as a result.

War redefines the terms "multiple trauma" and "massive injuries." The wounds sustained in battle frequently result in disfigurement, dismemberment, and/or severe disability. Many war injuries require multiple surgeries, long-term hospitalization, and rehabilitation, and patients often have to adjust to a style and quality of life that, if not seriously compromised, is significantly altered. Anecdotes from Vietnam indicate that the psychological care patients received immediately after they were injured and during the long months of hospitalization that followed (both in military and VA facilities) was inadequate.[1-5] This points to a resounding need for a new health care approach that will help these patients deal with the trauma of their war experiences and related injuries more effectively.

One myth circulating in the late 1970s contended that war-injured veterans had fewer psychological problems than did their noninjured counterparts. This has been largely discounted by the findings of the 1988 National Vietnam Veterans Readjustment Study, which revealed that Vietnam veterans with service-connected physical disabilities have a higher rate of post-traumatic stress disorder (PTSD) than do their nondisabled contemporaries, and were more likely to be currently unemployed, unmarried, and dissatisfied with their lives.[6]

On the other side of this issue are the reports from the caregivers throughout the medical evacuation chain who have expressed feelings of inadequacy, guilt, and helplessness, having perceived a personal inability to provide the support they knew their patients needed.[7-13] In talking with health care providers who served during the World War II, Korean, and Vietnam eras, Furey and VanDevanter found that those feelings are not limited to the first-line caregivers, but are experienced by health care personnel at all levels who care for combat casualties.[13]

It is also important to recognize that as the war-injured patient progresses through the medical evacuation system, his or her need for psychological support grows rather than diminishes. In the initial stages of care, the primary concern of the health care team and the patient is saving life or limb, relieving pain, getting home, and being safe. As survival and safety are assured, and as pain is controlled or reduced, the veteran must come to grips with what has happened. What's in store? How is the family going to respond? Will the patient ultimately be healthy, physically attractive, sexually capable, or emotionally able to endure the months of treatment that may lie

Table I: Critical elements of proposed model for mental health consultation in combat casualty care.

1. Outlining the role of the mental health consultant
2. Preparing staff for treating combat casualties
3. Scheduling and conducting meetings of health care team
4. Setting up and conducting patient groups
5. Providing staff stress debriefings

ahead? As these questions and concerns take precedence in the casualty's mind, his or her need for some kind of response from the health care team will increase.

The professionals who will bear the brunt of fulfilling this need are the nurses, rehabilitation therapists, and attending physicians, who have daily contact with the patients. Unfortunately, we often underestimate the value of this daily contact on the psychological adjustment of the patient and family, and at the same time fail to fully appreciate the emotional, physical, and spiritual toll it can take on staff. Caring for large numbers of war-injured patients can be an overwhelming task for hospital personnel, and can result in their own emotional withdrawal from the patients and their pain. When this distancing occurs, everyone suffers: The patients' needs are not met, and as their demands intensify, the staff experiences debilitating burnout.

Over the years, psychological consultation/liaison services to medical and surgical units have been established in VA hospitals to help patients and staff with the consequences of emotionally provocative injuries, illnesses, and related decision-making. However, these services do not always address the issues sufficiently. Psychiatric/psychological consultation often involves little more than an independent interview with the patient by a mental health professional, a chart note containing recommendations, and little or no direct communication between the staff and the consultant. Typically, ongoing support, consultation, and follow-up care are minimal, and caregivers frequently implement separate plans of care based on their individual perceptions of the patient's needs. This results in disjointed treatment and sends out confusing or conflicting messages to the patient. Such practices cause personnel to work against rather than with each other.

THE MENTAL HEALTH CONSULTANT MODEL

We propose a model for mental health consultation in medical and surgical areas that relies on five critical elements, which we believe has particular relevance in the care of combat casualties (Table I). This model was implemented and utilized successfully in a long-term care setting at VAMC, Bay Pines, Florida, from 1986 until 1989, and is currently being used on that facility's oncology unit. In this model, the mental health consultant becomes a participating member of an integrated team that provides ongoing care to the veteran. Staff members receive substantially more support and guidance in their dealings with one another and with the psychological issues confronting patients and their families. This model empowered personnel in the Bay Pines VAMC long-term care setting to provide more sophisticated emotional and psychological support to veterans and their family members. Patient compliance with treatment increased, as did rapport among the staff.

We initially used this model with long-term care patients at Bay Pines who were relatively young; almost all were Vietnam or Vietnam-era veterans undergoing major life changes: a 42-year-old stroke victim with significant hemiparesis; a young spinal cord injury patient with bilateral above-the-knee amputations, serious sacral decubitus, and considerable treatment noncompliance; a man in a persistent vegetative state, whose family wished to discontinue enteric feedings; and the first AIDS patient admitted to the long-term care setting. Certainly, these patients differ from combat casualties, but with appropriate modification, the mental health consultant model can be effective in almost any environment. For example, a form of this intervention successfully helped Bay Pines staff deal with a patient's suicide.

IMPLEMENTATION

Outlining the consultant role. In preparing staff for the implementation of the mental health consultant model, it is essential that the medical center administration actively support the consultant as a team member. The consultant has five primary responsibilities: cofacilitating staff preparation sessions; participating at team meetings; assisting in care plan development and implementation; engaging in direct care (therapy); and organizing staff and patient groups.

Staff preparation. Personnel need to be prepared for the type of patients they will be treating and be familiar with the physical and psychological injuries to which they will be exposed. War wounds are often quite dramatic and frequently shocking to the uninitiated, and the nature and extent of the injuries can overwhelm even the most experienced staff member; being exposed to war injuries in large numbers can be exceedingly stressful both personally and professionally.

Some understanding of the combatants' experiences in the war zone can sensitize staff to the emotional state of the patient prior to the latter's arrival at the facility. Traumatic injuries typically occur suddenly and without warning under battlefield conditions. The wounded soldier often is left to wait in the chaos of the battle for evac-

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uation to a medical facility. Upon reaching that facility, the casualty becomes part of the fast-paced and emotionally charged triage process and may be placed aside while those in greater danger are treated. During this period, the patient learns more about the nature and severity of the injury, wonders about chances of survival, and envisions the fate of those still on the battlefield. Many casualties are informed of the loss of an appendage or the extent of an injury upon waking from surgery.

Once stabilized, the veteran is evacuated from the war zone and may experience short stays in any number of medical facilities prior to reaching a stateside hospital. As a result, many persons will have been involved in their care, changing their treatment regimen and working on their wounds. Each move toward home means new staff, new approaches to care, and new ambiguities and concerns regarding adjustment and return to civilian life.

Upon arrival at a stateside facility the veteran is frequently concerned not only about his or her own future, but also about the family's response to the injury. These concerns can manifest themselves in many maladaptive ways, including various forms of acting out characterized by angry outbursts, noncompliance with the medical regimen, social withdrawal, and expressions of ambivalence regarding survival. Similar maladaptive responses can occur in unprepared hospital personnel who find themselves confronting disfigurement caused by war wounds, the physical and emotional demands of the casualties, and their own values regarding quality-of-life issues. Discussing these reactions early on with the mental health consultant and supervisory staff will help personnel address problems in working with combat casualties and will provide a review of basic communication skills, empathic responses, and emotional assessment activities.

Team meetings. The consultant and the medical/surgical staff, including the attending physicians, rehabilitation therapists, nursing personnel, and social workers, should schedule at least two team meetings per week. The more frequently personnel attend the meetings, the more effectively they will be able to care for the wounded. The meetings should include a review of the patient's condition, prognosis, treatment plan, behavior, compliance, family issues, and interaction with staff. Staff members should feel free to express their response to the patient and any related feelings of frustration, inadequacy, and anger. This process enables the consultant to influence the plan of care, and allows those patients who require more formal assessment or intervention by a mental health professional to be identified and pursued.

Maladaptive responses can occur in hospital personnel who are confronted by disfigurement

A plan of care developed in this manner has the advantage of benefiting from the input of all parties involved in the patient's care and ensures commitment from them. Frequent meetings to review and revise the care plan provide greater opportunities to teach staff about the value of patient contracts, of compromising on excessively rigid regimens, and of involving the veterans and families in the course of treatment.

It is important for the consultant to remember that the nursing staff works across three shifts, and that the plan of care be communicated accordingly. Both the nurse manager and the consultant should provide opportunities for the evening and night staffs to discuss their feelings about the patients and their families. When communication is encouraged in this way, the mental health professional functions as a "pipeline" between shifts, fostering an understanding of the issues faced on the different tours of duty, sharing the similarities of each staff member's experience, and facilitating continuity of care over the 24-hour period. The consultant should be comfortable in sharing his or her assessment of the patient with the staff, and should not work with the patient in isolation from the other caregivers, since doing so would undermine the team concept and could result in tension and dissatisfaction on the part of other personnel.

Organizing groups. Once the health care team is functioning effectively and the patient's needs are assessed, the mental health consultant can set up groups that will help the veterans address the issues that concern them. War zone debriefing, adjustment to disabilities, and family issues are topics for groups that may be beneficial to these patients. Having the nurses, rehabilitation therapists, or social workers function as cofacilitators with the consultant was helpful in our experience, as their presence provided clinical expertise relating to the patient's illness or injury, and seemed to reinforce the team's identity and promoted continuity of the plans developed in the group.

Staff stress debriefing. Caring for severely injured and disabled patients may cause health care personnel to experience significant degrees of stress. Patrick identifies six demands that commonly contribute to stress in health care workers: demands for emotional, physical, social, or spiritual interaction with patients; demands generated by specific patient groups; intensity of work demands; decisions, either contemplated or made, that involve quality-of-life issues; the manner in which personal values influence how decisions are made, as well as the types of decisions made; and making both popular and unpopular decisions.[14] Although these factors are

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considered to be part of the job, they also represent a chronic source of stress that can become a serious personal burden.

In their model of emotional structured preparedness, Gusman and colleagues contend that all health care professionals have a history of experiences that places them at risk when confronted with victims of trauma.[15] These investigators point out that mental health workers who have been victims themselves in the past are at risk for experiencing greater stress when working with trauma victims. One doesn't have to be a victim, however, to relate to a patient's story at a deep emotional level. The authors also note that overidentification with the victims are a common way for staff to cope with the strong emotions frequently generated by empathizing with them, and as a result, the caregiver may adopt a blaming, helpless stance, which inhibits positive actions.

Working in concert with a mental health consultant can enhance care and diminish stress

Other professionals may err in the opposite direction by withdrawing or emotionally distancing themselves from the patients. At an unconscious level they may be feeling grateful that they are not the victim themselves and/or may have their own doubts regarding the victim's ability (as well as their own, should they find themselves in a similar situation) to adjust to the changes the injuries may require.

Finally, Gusman and coinvestigators point out that projecting one's own feelings about war, disabling injuries, and disfigurement onto the current situation poses a common threat to health care personnel working with victims of trauma, and may therefore influence their approach to the patient.[15] Structured staff debriefing activities and implementation of the emotional structured preparedness model provide complementary approaches to supporting personnel who render care to combat casualties.

SUMMARY

Effective mental health consultation can make a significant difference in the combat casualty's adjustment to injury, and in the hospital staff's ability to help those patients understand their emotional responses to the changes wrought by those injuries. Although such a task would overwhelm any single individual who has other health care responsibilities, an integrated team of professionals, working in concert with a mental health consultant, will enhance the plan of care and diminish the stress experienced by both patients and staff. This, in turn, will foster the veteran's emotional and physical recovery from the sequelae of combat exposure.

REFERENCES

1. M. Cleland, *Strong in the Broken Places* (Chosen Books Ltd., Lincoln, Virginia, 1980).
2. F. Downs, *Aftermath* (William Norton & Co., New York, 1984).
3. A. Nigut, "Psychological Response to War Injuries," paper presented at VA workshop: Diagnosis and Treatment of Post Traumatic Stress Disorder in the Veterans Administration (Orlando, Florida, April 1987).
4. S. Tice, "PTSD in the Physically Disabled Veteran," paper presented at VA workshop: Advanced Clinical Skills in PTSD (San Antonio, August 1990).
5. G. Mays, "Psychological Aspects of War Injuries," paper presented at VA/DoD workshop: Interventions in Traumatic Stress (Indianapolis, December 1990).
6. R. Kulka, W. Schlenger, J. Fairbank, et al., *Trauma and the Vietnam War Generation: The Findings of the National Vietnam Veterans Readjustment Study* (Brunner & Mazel, New York, 1990).
7. F. Shea, *The Stress of Caring for Combat Casualties* (U.S. Navy Medicine, January–February, 1983) pp. 4–7.
8. L. VanDevanter, *Home Before Morning* (Beaufort Books, New York, 1983).
9. K. Walker, *A Piece of My Heart: Stories of Twenty-Six American Women Who Served in Vietnam* (Presidio Press, Novato, California, 1986).
10. E. Norman, *Women at War: The Story of Fifty Military Nurses Who Served in Vietnam* (University of Pennsylvania Press, Philadelphia, 1990).
11. J. Wolfe, "PTSD in Women Veterans," paper presented at VA/DoD workshop: Interventions in Traumatic Stress (Indianapolis, December 1990).
12. J. Furey, "Women Vietnam Veterans: A Comparison of Studies," *Journal of Psychosocial Nursing* **29**(3) (1991).
13. J. Furey and L. VanDevanter, *Visions of War: Dreams of Peace. The Writings of Women Who Served in Vietnam* (Warner Books, New York, in press).
14. P. Patrick, *Health Care Worker Burnout* (Inquiry Book, Blue Cross/Blue Shield, Chicago, 1981).
15. F. Gusman, F. Abueg, and M. Friedman, "Emotional Structured Preparedness: A Comprehensive Model for the Management of Traumatic Stress," paper presented at the sixth annual meeting of the Society for Traumatic Stress Studies (New Orleans, October 1990). □

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